DDES INFO MEMO 2004- 03 June 22, 2004

STATE OF WISCONSIN
Department of Health and Family Services
Division of Disability and Elder Services

To: Adult Day Care Programs
Adult Family Homes
Ambulatory Surgery Centers
Area Administrators/Assistant Area Administrators
Certified Mental Health and AODA Programs
Community-Based Residential Facilities
County Departments of Community Programs Directors
County Departments of Human Services Directors
County Departments of Social Services Directors
County/Tribal Aging Unit Directors
Division Administrators
DDES Bureau / Office Directors
End Stage Renal Disease Programs
Facilities for the Developmentally Disabled
Home Health Agencies
Hospice Agencies
Hospitals
Long Term Support Coordinators
Lead Elder Abuse Agency Contacts
Nurse Aide Training Programs
Nursing Homes
Outpatient Physical Therapy/Speech Pathology Services
Resident Care Apartment Complex
Rural Health Clinics
Tribal Chairperson/Human Services Facilitators

From: Sinikka Santala
Administrator

Re: Domestic Violence in Later Life and Sexual Assault Incidents Occurring in Facility Settings – A Resource Memo

Purpose of Memo

The reason for this memo is to underscore the problems of domestic violence in later life and elder sexual abuse occurring in health care facilities, and to provide access to resources related to those topics. A significant amount of information is available to community based providers and the purpose of this memo is to provide information to residential providers. The memo addresses situations that involve sexual assault perpetrated by anyone (e.g., family member, another resident, stranger, volunteer). It also addresses domestic violence in later life, which is defined as a **pattern** of coercive control that an abuser exercises over an older adult; typically, the abuser is a spouse, adult child or other family member. Caregiver misconduct is addressed in this memo **only** as it applies to incidents involving sexual assault and domestic violence in later life. For a full discussion of what comprises caregiver misconduct and a facility's responsibility to respond to caregiver misconduct, please see the Bureau of Quality Assurance (BQA) Caregiver Program website at:
http://www.dhfs.state.wi.us/caregiver/contacts/Complaints.htm

Case Examples

The problems of domestic violence in later life and elder sexual assault are far more pervasive than most care to admit. The following cases occurred in Wisconsin during the past years and illustrate the range of sexual assaults taking place in long-term care settings. Cases that illustrate domestic violence in later life (DVLL) are also included.

- While employed as a caregiver (nurse aide) at a nursing home located in a northern county, the caregiver failed to wear gloves as required when providing perineal care and also made disrespectful and inappropriate comments to the resident when providing the care. As a result of the failure to wear gloves as required, the resident's skin became irritated from the nicotine on the caregiver's hands. Furthermore, after cleaning the resident's genital area, the caregiver smelled his fingers and said to her, "That's how I check for a yeast infection on a woman."

- A resident with dementia relies on staff for assistance with personal cares, including incontinence care, and was observed with a disheveled appearance, dirty clothing, and a strong body odor. Surveyors observed the resident, wearing only a T-shirt, being escorted by two staff from the dining room. Staff did not attempt to cover the resident's exposed body, including the resident's genitals and buttocks. In addition to survey staff, two other residents were present. One of the other residents shook her head, laughed, and stated, "Ah, that's too bad."

- Resident, age 101, lives in a nursing home. Her son-in-law was observed having sexual contact with her. Although the resident acknowledged that the sexual contact was occurring, she did not want it reported. Her son-in-law had told her that he would hurt her daughter (his wife) if she resisted. Trying to protect her daughter, who was also a resident at the nursing home, the resident never told anyone about the abuse, until she was asked about it.

- An 84 year-old female resident was admitted to the facility under emergency protective placement following hospitalization for "severe ecchymosis and swelling of her face." The resident, in the previous months, had been treated for fractured ribs, fingers, and arm and had a history of shoulder and elbow fractures. It was suspected that her husband was abusing the resident. While at the nursing home, the resident's husband was heard yelling at her and she was crying, "Help! Ouch." After the husband left, the resident told the nurse aide that "he knows where I am…he'll come here anyway. That's how my arms got broke and my eyes bruised. And it hurts so bad when he pulls my arms." Subsequent incidents were charted over the course of several months including the occasion when the husband returned the resident to the facility following an outing and the resident was bleeding from the forehead. Another time the husband slapped the resident and told her he would do it again if she didn't shut up. Later the husband hit the resident with a fly swatter. The following day he fed the resident so fast that she choked. When the resident returned from another outing with her husband, she was crying and had dried blood around her mouth. The resident stated her husband had hit her in the mouth. The husband stated she had bumped her mouth and the social worker charted it as such without having done an investigation. The husband slapped the resident yet another time. The resident stated, "I want him to keep coming to visit me every day, I just don't want him to hit me. He likes to fight with me and hit me."

Source Material

This memo provides information about clear and assertive responses to the case examples listed above that draw upon state, county and provider expertise and collaboration. Working together, needed victim services can be provided in a timely and appropriate fashion. In addition, collaborative efforts can result in prevention and earlier intervention. The remainder of this memo outlines how social services, regulatory, law enforcement, and advocacy agencies can work together to address elder sexual assault and domestic violence in later life, including potential roles and responsibilities. In addition, the memo provides links to various state and national web sites that feature additional background materials (see: http://dhfs.wisconsin.gov/caregiver/ElderAbuse.htm). The sites also list organizations that may be able to provide you with consultation and technical assistance.

The information for this memo and the memo attachments come from a variety of sources including the Wisconsin Coalition Against Sexual Assault, the Wisconsin Coalition Against Domestic Violence/National Clearinghouse on Abuse in Later Life (NCALL), the National Organization for Victim Assistance (NOVA) and this Division's Bureaus of Quality Assurance and Aging and Long Term Care Resources. The resource listing is intended to be a beginning, and will be updated as new resources are identified. If you have any additional resources, materials or other information related to domestic violence in later life and/or elder sexual abuse in facility settings that should be added, please contact:

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Statutory/Regulatory Basis

Although this is a best practices guide (compared to mandated procedures), please note that sexual assault and domestic violence statutes as well as client rights' codes govern responding to elder sexual assault and domestic violence in facility settings. These include Wisconsin State Statutes §50.09(1)(k), §51.61(1)(m), §940.285, §940.295 and Wisconsin Administrative Codes HFS 94 and 132. A list specific to abuse, neglect and exploitation that details components of these statutes and codes is summarized as follows:

- Residents have the right to be treated as an individual, with courtesy, respect and dignity in the environment in which they live.
- Facilities have a duty and legal obligation to provide a safe and humane psychological and physical environment for residents.
- Facilities must maintain or enhance each resident's dignity and self-worth. No one should humiliate, harass or threaten a resident.
- All people, regardless of age or infirmity, have the right to live free from financial, verbal, sexual, physical and mental abuse, punishment and isolation.
- Abuse and/or sexual assault must be appropriately addressed in order to:
  (1) protect the victim/survivor from future assault/abuse;
  (2) assist the victim/survivor in healing from the assault/abuse; and
  (3) prevent the abuse and/or sexual assault of others.
- Every resident has the right to voice grievances about the care and treatment they receive without discrimination or reprisal and the right to prompt efforts by the facility to resolve any concerns or complaints.

In addition, the sexual assault criminal statute, Wisconsin State Statute §940.225, and the domestic violence mandatory arrest law, Wisconsin State Statute §968.075, may also apply when certain illegal actions have taken place.

Problem Statement

It is important that the awareness of sexual abuse among residents, facility staff, law enforcement, and helping agencies is increased. Domestic violence can occur in residential care settings as well as non-institutional settings. We need to be aware that older people, especially those with physical or cognitive limitations, can be abused and/or sexually assaulted by family members, friends, neighbors, and other adult acquaintances in facilities designed to provide care. Unfortunately, because such domestic abuse and sexual violence is rarely recognized, it often is not appropriately responded to by many professionals or the community at large.

Lack of awareness and recognition of these types of crimes committed against older adults reinforces the reality of underreporting. In addition, many victims do not report out of fear of retaliation or what might happen to them or the perpetrator or may have been abused so long that they do not see any way out of

the situation. Residents may be isolated and not have anyone other than paid staff to tell. Family, friends and volunteers may not have information about the signs of abuse or what to do if they suspect a problem, especially if the older person does not communicate verbally. When facility staff identifies abuse, there may be confusion about whom to call and what to do or reluctance to report because they don't want police involved or regulatory action started.

Responding To Abuse

The current response to older persons residing in facilities who have experienced abuse and/or sexual assault needs to be strengthened. Too often professionals in a variety of disciplines do not have the information and resources they need to respond appropriately, effectively and sensitively. These cases may be complicated. Determining the best way to hold offenders accountable will vary, depending on the circumstances and whether the perpetrator is a family member, caregiver or resident. In situations involving domestic violence in later life, abusers use a variety of tactics to gain and maintain power and control over their victims. Similarly, many abusers will sexually assault/abuse their victims to demonstrate power and control over the victim. However, in later life, some older perpetrator's sexual offending and abuse may be the result of a manifestation of an illness or a condition related to dementia. Regardless of the motivation behind the assault/abuse, ending the abuse and supporting the victim are paramount. Holding abusers accountable and keeping victims safe requires different responses in different situations.

There are three basic components to responding to older victims of domestic violence or sexual assault in facility settings. The first is to **recognize** it. The second is to **react**. And the third is to **refer**.

1. Recognize

If someone tells you he or she has been hurt or is afraid, consider that abuse may have occurred. Even if you have reason to doubt the abuse is real or have misgivings about other things that the person tells you, do not immediately dismiss the allegation. Instead, **consult** with a colleague to gain additional perspective. You may choose to consult with staff from the Bureau of Quality Assurance (BQA) (caregiver_intake@dhfs.state.wi.us or 608-243-2019) or an ombudsman with the Board on Aging and Long Term Care (http://longtermcare.state.wi.us/home/). Other options include contacting the county elder abuse agency or a sexual assault or domestic violence program in your area to gain insight and possible advice. (For a list of elder abuse agencies, please go to: http://dhfs.wisconsin.gov/aging/elderabuse/agencies.htm. For a list of domestic violence programs, please go to: http://www.wcadv.org/?go=gethelp/local. For a list of sexual assault programs, please go to: http://www.wcasa.org/findhelp/index.html.) Calls to elder abuse, sexual assault and domestic violence agencies can occur in an anonymous fashion, i.e., there is not a need to provide identifying information specific to your organization or the resident you are concerned about.

[Note: To assist you in identifying both domestic violence in later life and elder sexual assault in facility settings, additional information (e.g., definitions, indicators of abuse, perpetrator types, why elders are vulnerable) may be found attached to this memo in Appendix A.]

2. React

Initial Response

Once a case of **elder sexual assault** is identified, there are some crucial steps that should occur immediately. They are as follows:

1. Provide non-judgmental emotional support.
2. Provide protection from the abuser – for ongoing abuse to continue, secrecy and victim isolation are necessary. Consider the safety of the victim and yourself before taking action.

3. Provide needed medical care. Be careful to preserve evidence, e.g., do not bathe or shower the resident or change his/her clothing or bedding[1].
4. **Report/refer case to proper authority (ies). (**Please see the section/table that follows in this memo titled "*Professionals and Their Roles and Functions*" for a list of individuals/agencies you may choose to report to.)
5. Ensure throughout the entire process the thorough and accurate documentation of information, observations and facility decisions[2]. (For guidance on record keeping, please see the section that follows in this memo titled "*The Importance of Documentation*.*"*)

When you do learn of sexual assault/abuse, do not be hesitant to report it. It is your right as a resident, facility employee, county social worker, family member, friend or interested other to report and to have appropriate agencies, including law enforcement, respond. Delays in reporting greatly hinder investigations and prosecution of abusers.

Once a case of **domestic violence in later life (*that does not involve sexual assault)*** is identified, the initial response should be identical to elder sexual assault, steps one through five listed above. However, in executing step number four, the entity may decide to report or not report the situation to an individual(s) who works outside of their immediate organization. **An entity should report to appropriate outside agencies whenever any of the following occurs:**

1. Whenever the individual (the alleged victim) requests a report be made;
2. Whenever the elder adult-at-risk is incapable of seeking help;
3. Whenever the elder adult-at-risk is under guardianship or has an executed durable power of attorney for health care. (Note: If the alleged abuser is neither the guardian and/or agent, a report should be made to that legal representative so that s/he may carry out his/her responsibilities in defending the rights of the alleged victim. **However, if the alleged abuser is believed to be the guardian and/or health care agent, at minimal, a report should be made to your county's adult protective services agency**.);
4. Whenever the elder adult-at-risk is in imminent life-threatening danger; and/or
5. Whenever there are other adults-at-risk that are at risk of serious bodily harm, death, sexual assault, or significant property loss inflicted by the suspected perpetrator.

The rationale for an entity to potentially not report an incident of domestic violence in later life to an external agency is based on the need for victim safety (trusting the victim to know what is best for him/her) and the principles of self-determination and empowerment. When an incident of domestic violence in later life involves a **competent victim** and the **event does not constitute a crime** (e.g., potential emotional abuse as demonstrated by yelling and shouting), then the facility may defer to the wishes of how the victim would want to proceed. In these circumstances (victim is competent and incident does not constitute a crime), it does not matter if the incident was witnessed by staff or was a result of victim disclosure. Recognize that factors such as loyalty, love or loneliness often keep the victim from severing the relationship with the abuser. The victim's goal is often to have the relationship continue – just not the abuse.

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[1] It is recommend that evidentiary exams be completed *within ninety-six (96) hours* after a sexual assault. However, post *ninety-six (96)* hour exams can be done if the victim reports (1) pain or bleeding, (2) an unusual amount of force was used in the assault, (3) ejaculation occurred without clean-up or (4) in case by case exceptions. (Source: "The Elderly Victim of Sexual Assault and SANE [Sexual Assault Nurse Examiner]" power-point presentation prepared by C. Jill Poarch, RN, BSN, SANE and Kim Macauly, RN, BSN, SANE, Meriter Hospital SANE Program, Madison, WI, 2003.)

[2] Note: When developing sample policies and procedures for responding to sexual assault in facility settings, see Appendix B "*Suggested* Sexual Abuse Response Protocol" developed by the Sexual Assault/Domestic Violence Industry Training Advisory Group, Department of Health and Family Services, August 2003.

In these circumstances an empowerment model of offering information, options and assistance is much more likely to be successful and not put the victim at greater risk. Find out what the victim wants to have happen and support those decisions as best you can. Victims of abuse can benefit simply from being heard, believed and supported. Identify ways that the victim can increase safety when the abuser visits. For example, inquire if the resident would want to meet in a public place (e.g., dayroom) rather than his/her own room – the additional eyes and ears may help to keep the abuser in check. Likewise, you may ask the victim if they would prefer not to go on a day or weekend pass with the abuser but rather stay at the facility and if the answer is yes, then provide the excuse for the victim to do so.

What to Say and Do if You Must File a Report of Elder Sexual Assault and/or Domestic Violence with an External Agency

Informing the resident can be done respectfully. Discuss with the resident that you must report and why. Say for example: "I have heard your concerns about contacting law enforcement (adult protective services, ombudsman program, etc.). However, I am compelled under state statutes (federal laws, professional code of ethics, facility protocol, etc.) to report cases such as yours. I am very concerned about your health and safety. I would like to take the time now to talk with you (and, if appropriate, with your family, guardian, friend, etc.) about safety planning and follow-up services (e.g., medical appointments, counseling, execution of legal documents, etc.)."

The Importance of Documentation

Collecting thorough information improves the likelihood that the first response and/or investigation yield satisfactory resolution(s). No inquiry is complete without thorough documentation of every step along the way. Since documentation can serve as a legal document and an official record, the following needs to be considered:

- Information should be systematically presented, well organized and legible.
- Behaviors should be described rather than interpreted and facts reported objectively. Do not write judgment statements about the victim such as "she was hysterical and overreacting" or "he was evasive." This is an opinion; the reaction may have been perfectly appropriate given the circumstances.
- The written history should include information about who caused the injury, how the injury occurred and if the injuries are consistent with the resident's explanation of the cause. Avoid language such as "alleges" which suggests you do not believe the information given.
- It is useful to document the actual words of the victim and others interviewed, and all sources of information should be included.
- Document injuries by taking photos or drawing on body maps.
- Document where report(s) of the incident(s) were made[3] (e.g., charge nurse, facility administrator, law enforcement, Bureau of Quality Assurance, lead elder abuse agency), what interventions were offered (e.g., social services, counseling, safety planning, medical treatment) and the outcomes (e.g., accepted brochures, consulted with a social worker, obtained temporary restraining order). You should also identify, if applicable, any individuals you consulted with concerning any aspect of the case.

[3] If you did not file a report with an external agency about an incident of domestic violence in later life which involved a **competent victim but did not constitute a crime,** you should document rationale for doing so. Sample entry could read: "After discussing with the victim the situation (including options that could be explored) and receiving direction as to how s/he would like to proceed, I did not believe filing a report with an outside party would be in the best interest of the victim."

3. Refer
Where to Report

The key systems that should respond to reports of domestic violence in later life and elder sexual abuse in a facility setting are social services (elder abuse and adult protective services), regulation and licensing, criminal justice including victim services, and, advocacy organizations. Frequently healthcare is another system that plays an important role in responding to reports of elder physical and sexual abuse. An understanding of which agencies are responsible for investigating abuse and which individuals within those agencies are responsible for receiving complaints is necessary to ensure appropriate, timely referrals from institutions.

PROFESSIONALS AND THEIR ROLES AND FUNCTIONS

Professional	Roles and Functions Involving Cases of Domestic Violence and Sexual Assault of the Elderly
County Adult Protective Services (APS) Worker	▪ In cases involving emergency protective placement and/or services, the worker should be monitoring placement and/or service delivery to ensure an individual's well being. ▪ If initial placement was due to suspected abuse, neglect or exploitation of a resident, that concern should be shared with facility staff at time of admission. Facility staff should be instructed in their role regarding resident safety. ▪ During the annual WATTS review of the protective placement, worker should identify through review of resident's file, any patterns of abuse, neglect or exploitation. If so, an investigation should occur. ▪ Protective actions (e.g., domestic violence restraining order) should be identified and pursued.
Facility Staff	▪ Facility should have a protocol for recognizing and responding to incidents involving abuse, neglect and exploitation. ▪ Staff should be trained on this protocol. ▪ Staff should implement screening tool to identify prior history or current occurrence of physical abuse, sexual assault, neglect and/or exploitation of facility residents. ▪ Staff should report suspected abuse/sexual assault to law enforcement and/or the county elder abuse agency for investigation.
Client's Rights Specialist	▪ All providers/facilities are required to have an identified/designated Clients Rights Specialist (CRS) to investigate any HFS 94 rights issue raised or complained of by client/guardian/staff/friend. ▪ The CRS should problem solve and pursue informal resolution if possible – or complete investigation report as part of HFS 94 "Grievance Resolution Procedure (GRP).
Board on Aging and Long Term Care Ombudsman	▪ An ombudsman is especially good at promoting the rights of the resident and could utilize mediation in doing so. ▪ An ombudsman could assist a facility in problem solving difficult situations.
Department of Regulation & Licensing (DRL)	▪ DRL investigates allegations when the abuse, neglect or exploitation involves an individual who is required to hold a credential, as defined in s. 440.01(2)(a), under chs. 440 to 460 (e.g., nurse, doctor, social worker, psychologist, etc.).
Bureau of Quality Assurance (BQA)	▪ BQA sections (Assisted Living, Health Services, Residential Care Review) investigate facility culpability for misconduct incidents. ▪ BQA Office of Caregiver Quality investigates allegations of abuse or neglect of a client or misappropriation of a client's property when the incident involves noncredentialed staff, e.g., certified nursing assistant (CNA), direct care worker.

PROFESSIONALS AND THEIR ROLES AND FUNCTIONS (Continued)

Professional	Roles and Functions Involving Cases of Domestic Violence and Sexual Assault of the Elderly
Elder Abuse Worker	▪ Based on seriousness of allegations, a referral to law enforcement could be made. ▪ The elder abuse worker should work with the domestic abuse and/or sexual assault service providers in the county to determine victim-centered services, including appropriately tailored safety plans.
Domestic Violence / Sexual Assault Advocate	▪ In addition to developing safety plans, counseling and legal advocacy (e.g., obtainment of a restraining order) could be made available.
Medical Provider	▪ During physical exams and emergency treatment for injuries, individuals should be screened for domestic violence and sexual assault. ▪ If injuries are believed to have occurred as a result of a crime, evidence collection should occur and a report to law enforcement should be made. ▪ Documentation of abuse should occur in the patient file.
Law Enforcement	▪ Upon report of abuse, investigation should occur. ▪ If criteria for a domestic abuse mandatory arrest is met, arrest of the perpetrator should occur. ▪ A referral should be made to the local district attorney's office, the Wisconsin Department of Justice, or the U.S. Attorney's Office for prosecution.
Victim Witness or Victim Advocate	▪ Generally work in the prosecutor's (county district attorney's) office. ▪ Will educate victim on the criminal justice process if an abuser has been arrested.

Prevention/early detection is a critical component in providing a safety net for Wisconsin's most vulnerable populations. As identified above, older victims benefit from a coordinated response to situations involving abuse, neglect and exploitation. **County elder abuse interdisciplinary teams** (I-teams) are a way to educate in advance the professionals involved and their role in responding to abuse, neglect and exploitation. An I-Team is a group of selected professionals from a variety of disciplines who meet regularly to discuss and provide consultation on specific cases of elder abuse, neglect or exploitation. ***(In some counties, social workers from nursing homes participate. In other counties, a long term care ombudsman serves on the team.)***

If your entity is seeking guidance on how to proceed with a case of sexual assault or domestic violence in later life, contact your county's lead elder abuse agency representative and, if timely, ask to be placed on the next I-team meeting to discuss the situation. Otherwise, ask the I-team coordinator's opinion about how to best proceed in getting additional insight (some agencies have a core group that can be pulled together for emergent cases, others have an electronic message board for seeking advice).

[Note: To assist a county in developing a "Phone/Contact Page" for referring cases of abuse, neglect and exploitation, see Appendix C.]

Summary Statement

The Department's goal is to end abuse, neglect and exploitation of Wisconsin's most vulnerable citizens. Regulatory oversight, facility practices and policies, and individual background checks are three methods of protecting vulnerable individuals from abuse, neglect and exploitation. However, one of the most effective prevention and intervention methods regardless of where a person resides is increased communication and collaboration among agencies. It is important that agencies coordinate efforts and resources. Information must be provided to residents, family members and care providers on how to identify abuse, neglect and exploitation and to report it.

This information memo provides facts specific to domestic violence in later life and elder sexual assault in facility settings and gives guidance on identifying, responding and referring cases in a timely, appropriate fashion. The memo also strongly emphasizes the need to collaborate with a wide variety of systems to most effectively meet the wishes of the victim, including victim safety, and to hold the abuser accountable.

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MEMO WEB SITE: http://dhfs.wisconsin.gov/partners/local.htm

c: Area Agencies on Aging Executive Directors
Alcohol and Drug Abuse Coordinators
Board on Aging and Long Term Care
Coalition of Wisconsin Aging Groups – Elder Law Center
DDES Facility Directors
Developmental Disabilities Coordinators
Mental Health Coordinators
Wisconsin Coalition for Advocacy
Wisconsin Coalition Against Domestic Violence
Wisconsin Coalition Against Sexual Assault
Wisconsin Council on Developmental Disabilities
Wisconsin Council on Mental Health

Attachments:
Appendix A – Facts About Domestic Violence in Later Life and Elder Sexual Assault Occurring in Residential Care Facilities
Appendix B – Background Information on the Sexual Abuse Response Protocol
Appendix C – Contact Information for Reporting Abuse, Neglect & Misappropriation (Financial Exploitation) Incidents

Appendix A

FACTS ABOUT DOMESTIC VIOLENCE IN LATER LIFE
AND ELDER SEXUAL ASSAULT
OCCURING IN RESIDENTIAL CARE FACILITIES

Compiled by Jane A. Raymond, DHFS/DDES/Bureau of Aging and Long Term Care Resources
Madison, WI – May 4, 2004

FACTS SPECIFIC TO ELDER SEXUAL ABUSE

WHAT IS SEXUAL ASSAULT?

Sexual activity that occurs under the following conditions is assaultive or abusive[1]:

- A person is **physically forced** into contact.
- A person is **threatened, manipulated** and/or **tricked** into contact.
- A person is **unable to consent** to sexual activity.
- An **owner or employee of certain residential facilities** has sexual contact or sexual intercourse with a person receiving services from that facility.[2]

A range of behavior may be involved in the sexual assault[3]:

- **Hands-off offenses** include exhibitionism; voyeuristic activity; forcing an individual to view pornographic materials; sexual harassment and threats.
- **Hands-on offenses** include kissing, touching/molesting breasts, genitals, and buttocks; oral/genital contact; penetration of vagina or rectum with penis, fingers or objects.
- **Harmful genital practices** involve unwarranted, intrusive, and/or painful procedures in caring of genitals or rectal area. This includes applications or insertion of creams, ointments, thermometers, enemas, catheters, fingers, soap, washcloths, or other objects when not medically prescribed and unnecessary for the health and well being of the individual. The practices meet the idiosyncratic needs of the offender, but not the health or hygiene needs of the victims. Perpetrators may appear obsessed with the behavior, claim that the harmful practices are required for health or hygiene reasons, and be reluctant to stop when instructed to by health care professionals. These practices may co-occur with hands-off and hands-on offenses as described above. Individuals with disabilities that render them unable to independently bathe, use the toilet, and attend to other personal needs are vulnerable to these practices.

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[1] Ramsey-Klawsnik, Holly. Widening The Circle: Sexual Assault/Abuse and People with Disabilities and the Elderly, 1998, Chapter 3, p. 10. (Wisconsin Coalition Against Sexual Assault, Madison, WI)

[2] Section 940.225(2)(g), Wis. Stats. In addition, Section 940.225, Wis. Stats. applies to certain programs and facilities and makes it a crime for a person in charge of or employed by the program or facility to intentionally, recklessly, negligently abuse a patient or resident of the program or facility regardless of whether injury or harm occurred. It also makes it a crime for any person in charge of or employed by the covered programs or facilities to knowingly permit another person to intentionally, recklessly, or negligently abuse a patient or resident of the program or facility, again regardless of whether injury or harm occurred. "Abuse" as defined in s. 940.295, Wis. Stats., includes conduct which is not necessary for the treatment or maintenance of order and discipline of a facility or program and which harms, intimidates, humiliates, threatens, frightens, or otherwise harasses the patient or resident.

[3] Ramsey-Klawsnik, Holly. Widening The Circle: Sexual Assault/Abuse and People with Disabilities and the Elderly, 1998, Chapter 3, p. 10. (Wisconsin Coalition Against Sexual Assault, Madison, WI)

WHO ARE THE VICTIMS?

Elder sexual assault victims are individuals age 60 and older, **or** who are subject to the infirmities of aging[4]. While the majority of identified abuse and/or sexual assault victims are female, males with special needs are also vulnerable. Some elder victims may be relatively healthy, requiring brief recuperative stays in a facility, yet abused by a family member in that setting. Others may be long term residents who are frail or have physical impairments or cognitive limitations.

WHY ARE ELDERS VULNERABLE TO SEXUAL ASSAULT?

Individuals perceived to be particularly vulnerable, or a potentially easy target, are often chosen for victimization by sexual predators. Older individuals may fall into this category because of the following factors.

- Physical frailty or diminished ability to defend themselves
- Need for assistance from others (e.g., transportation, bathing, health care, etc.)
- Predictable routines, schedules
- Living alone or in a congregate setting
- Dementia or cognitive impairments

Adults are **not** necessarily less susceptible to sex crimes as they age. Sexual abuse is motivated not by sexual desire, but by a desire to exert power and control over others and to humiliate and belittle the victim. We may become more vulnerable to abuse as we age. Old age and impairment decrease personal power and thereby increase the risk of abuse. Consequently, elderly and disabled individuals are sexual abuse targets.

WHAT ARE INDICATORS OF SEXUAL ABUSE?

PHYSICAL SYMPTOMS [5]

- Unexplained venereal disease or genital infections
- Vaginal or anal bleeding – injury to genital area
- Torn, stained, or bloody underclothing
- Difficulty sitting or walking
- Bruises or other signs of restraint
- Weight loss

[4] Section 46.90 (1) (c), Wis. Stats.
[5] "Sexual Abuse of Seniors" brochure (undated), Texas Association Against Sexual Assault, www.taasa.org

WHAT ARE SOME OTHER INDICATORS OF EXPLOITIVE SEXUAL ACTIVITY?

TIME AND LOCATION[6]

Exploitive sexual activity often occurs at a time or location unlikely to be selected by two consenting adults. For example, in a case involving a woman who was incontinent, an aide undressed her in the bathroom and left her seated on the toilet while the aide went to get a wash cloth and clean clothing. When the aide returned, she found a male resident standing in front of the woman. He had dropped his pants and was trying to force his penis in her mouth.

POWER DIFFERENTIAL[7]

The offender often has significantly greater ability than the victim does. While the victim and offender may both have a form of dementia, the victim's cognitive capacity may be significantly more compromised than that of the offender. For example, a perpetrator was verbal, ambulatory, and independent in eating and toileting. In contrast, his victim was quite passive and required assistance with all activities of daily living. The power differential may be physical, rather than cognitive. For example, a male resident walked into the room of a nonambulatory female, closed the door and molested her while she sat in her wheelchair, unable to remove herself from the situation.

NOTICEABLE AVOIDANCE OF A SPECIFIC RESIDENT[8]

A dynamic observed in many cases of resident sexual assault is one man demonstrating inappropriate desire toward multiple women. He may approach numerous women and attempt to force unwanted sexual contact. These attempts may not be limited to residents but involve female staff and visitors as well. For example, a male resident, described as big and strong, became sexually aggressive toward staff and residents. This resident continued to grope at the breasts and peri-area of any female within reach. In addition, the resident would make sexual gestures with his tongue. One charge nurse stated her breasts were black and blue from this resident. When the facility tried using a male CNA, the nursing assistant stated he had never been groped so much in his life.

CAN SOMEONE BE SEXUALLY ASSAULTED IF THEY HAVE THEIR CLOTHES ON?

YES. Sexual assault can occur when someone is fully clothed. Examples include: manipulation of breasts while the individual is wearing a blouse and bra and the probing of the genital area while the individual is wearing underwear under her nightgown. A "hands-off" example would be forcing a fully clothed individual to witness the perpetrator masturbating, while making sexual comments such as "you know how bad you want it."

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[6] "Elder Sexual Abuse Perpetrated by Residents in Care Settings." Holly Ramsey-Klawsnik, *Victimization of the Elderly and Disabled,* March/April 2004, p.94.
[7] Ibid
[8] Ibid

WHAT ABOUT SITUATIONS OF "CONSENSUAL SEX" INVOLVING A MARRIED NON-CONSENTING COUPLE?

Background

In order to not be considered abusive, sexual contact can only occur between consenting adults. Elements of consent[9] would include:

- Individual understands sexual nature of conduct
- Individual understands that the body is private and one has the right to not consent
- Individual understands consequences of sexual activity (e.g., risk of sexually transmitted diseases)
- Individual understands consequences of social taboos and societal responses

Case Example

Sometimes the ability to discern the element of consent can be quite challenging. Invariably, the following is one of the scenarios raised when facility staff ponder the application of consent:

"Married couple lives together in a nursing home. They actually share a room. Both have dementia and have been adjudicated incompetent. While it is firmly believed that neither can consent to sexual activity, they do indeed have sexual contact with each other – a continuation of a happy, married life together for some many years. It appears both individuals enjoy the contact, are seen holding hands together at socials, and always seek each other out"

Guidance Sought

As staff of the facility, you are aware of the sexual contact. What are you to do? Is this a criminal justice issue, a BQA enforcement issue and/or a facility staffing issue?

Response by DHFS

The individuals appear to be happy with the contact they have with each other even though they may not be viewed as capable of giving knowing consent. The quality of life for this couple is better because they are still a couple. By "seeking each other out" they seem aware of this despite their dementia. While there would be no criminal justice or regulatory enforcement response required in the situation described above, the facility would want to make sure that the respective guardians are aware of the sexual activity. It is suggested that the facility closely monitor the individuals' reactions. Document in their respective chart observations of the couple's behaviors. If there's a change – e.g., one appears to be bothered by the contact or there are indications of force used by one or another or non-consent/cooperation, then facility staff should intervene. This may include re-contacting the respective guardians and/or contacting the regional ombudsman program or county adult protective services agency for assistance in developing a victim safety plan and a care plan for the offender.

It is important to note the response is not based on the fact that they are a married couple and the role of husband and wife includes being sexually involved. Rather, it is based on the facts that the couple appears very loving, they seek each other out, and they seem to always be happy in each other's presence.

[9] Based on the Wisconsin Coalition Against Sexual Assault (Madison, WI) analysis of the case State v. Smith, 215 Wis.2d 84 (Ct. App. 1998)

An example of sexual activity involving a married couple where staff acted inappropriately follows:

> "A caregiver was discovered 'assisting' the sexual contact between husband and wife in a facility. Neither was aware of what was happening nor were they capable of consenting. She placed their hands on each other. She undressed each of them."

In this case, this was a sexual assault by the caregiver who disguised her conduct as "assisting the couple to enjoy each other". Subsequently, a hearing was held and the caregiver's name was placed on the Caregiver Misconduct Registry.

Summary Statement

Because the issue of consensual sex can become extremely complicated when involving individuals who have diminished capacity, it is recommended that when such a situation is identified, that advice be sought from others on how to best proceed. Studies have shown that decisions made by groups are more effective than those made by individuals when no one person has the solution, but each person can contribute to a solution. Given the complexity of these cases, and the fact that there are often gaps in the services needed to assist victims, a broad range of professionals looking at a case and planning possible interventions is more likely to arrive at effective results. Therefore, if your entity is seeking guidance on how to proceed with a case of possible sexual assault, call your county's lead elder abuse agency contact and if timely, ask to be placed on the next Elder Abuse Interdisciplinary Team (I-team) meeting for a discussion of the situation. You may also choose to consult with staff from the Bureau of Quality Assurance (BQA) (caregiver_intake@dhfs.state.wi.us or 608-243-2019) or an ombudsman with the Board on Aging and Long Term Care (http://longtermcare.state.wi.us/home/).

FACTS SPECIFIC TO DOMESTIC VIOLENCE IN LATER LIFE

WHAT IS DOMESTIC ABUSE IN LATER LIFE?[10]

While all intimate relationships have conflicts, an abusive power and control dynamic characterize abusive relationships. In an abusive relationship, one party fears the other and attempts to comply with the other's wishes to avoid the consequences of confrontation. Forms of domestic violence include, but are not limited to, physical, sexual, verbal and emotional abuse as well as financial exploitation. Often it is a combination of one or more of these types of abuse. It is important to understand domestic violence as a **pattern** of assaultive and coercive behaviors, designed to control another person. Abusers believe they are entitled to use any method necessary (e.g., use of threats and intimidation) to control how the victim thinks, feels and behaves. Abuse in later life can occur wherever the victim resides, which can include one's own home in the community or a residential care facility. When the abuser is a family member, spouse or trusted caregiver, it is likely the victim will want to maintain the relationship while ending the abusive behavior.

[10] Wisconsin Coalition Against Domestic Violence (Madison, WI) website: http://www.wcadv.org/index.cfm?go=gethelp/faqs#whatis (May 2004) and the National Clearinghouse on Abuse in Later Life (Madison, WI) website: http://www.ncall.us/#Definitions (May 2004).

WHO ARE THE VICTIMS?

Abuse in later life happens to people of all genders. Nationally reported cases of elder abuse indicate that about two-thirds of the victims are women, while one-third of the victims are men. While domestic violence programs in Wisconsin primarily serve women of all ages, many interventions such as safety plans, protective restraining orders and one-on-one counseling are useful and available for older victims of all genders.

FACTS THAT APPLY TO BOTH DOMESTIC VIOLENCE IN LATER LIFE AND SEXUAL ASSAULT OF THE ELDERLY

WHO ARE THE PERPETRATORS?

Anyone. Perpetrators may be family members, residents, or others.[11]

- **Family member:** (may take two forms i.e., (1) family member, or (2) spouse/partner.)
  - **Family members** (non-spouse) can include a parent, child, or grandchild, sibling, aunt, uncle, cousin, niece or nephew.
  - **Spouses or partners** can be abusive or sexually assault their mate. In some long-term relationships, the abuse may have been going on for 40, 50, even 60 years. In other situations, the relationship and abuse may be relatively new (generally following divorce or death of previous spouse). Sometimes onset of abuse may occur during older years due to medical conditions, such as Alzheimer's disease, that MAY manifest in violent or sexually inappropriate behavior.
- **Resident-to-Resident** abuse occurs in facility settings where a perpetrating resident forcibly (or in the absence of informed consent) engages in sexual contact or intercourse with another resident. The victim typically demonstrates decreased capacity in the areas of physical and/or mental health compared to the perpetrator.
- **Caregivers** may also be abusers. A caregiver is a professional, paraprofessional or volunteer providing services to an individual under a contractual or formal arrangement. This definition also includes "caregivers" as defined in Wisconsin law, section 50.065(1)(ag) 1., Wis. Stats.
- **Others:** Abuse may occur by persons who do not fit in the categories above. Sometimes these individuals are friends, neighbors or guardians of the victim. In these cases, the perpetrator is known and often has an ongoing relationship with the victim. In other cases, the perpetrator is a stranger. For example, a lay minister may visit residents at a nursing home but use this time as an opportunity to sexually prey on incompetent or frail elderly who may not be able to report the abuse.

[11] Ramsey-Klawsnik, Holly. Widening The Circle: Sexual Assault/Abuse and People with Disabilities and the Elderly, 1998, Chapter 3, p. 11. (Wisconsin Coalition Against Sexual Assault, Madison, WI).

The majority of identified abusers and sexual offenders are male. Female physical abuse and sexual offending does occur, however, and allegations involving female perpetrators also require careful investigation and intervention. While traditionally a perpetrator of domestic abuse has been described as an "intimate partner" (e.g., spouse, life partner or significant other), more recently the list of possible abusers has been expanded (e.g., adult children, grandchildren, nieces, nephews as well as caregivers) [12]. The expanded list of perpetrators acknowledges that older persons may have ongoing, trusting relationships with individuals they care about or love yet they are not physically intimate with.

WHAT ARE POTENTIAL PERPETRATOR BEHAVIORS? [13]

- Minimizes or denies abuse has occurred and instead blames the victim for being clumsy or difficult
- Attempts to convince health care workers that the patient is incompetent or grossly confused
- Senior is kept in an overmedicated state
- Overly protective or controlling of a family member (e.g., refuses to allow the elder to be alone with visitors, declines to leave the room during an exam, treatment or personal cares)
- Controls most of the resident's daily activities
- When visiting, either keeps door closed or frequently draws privacy curtain
- Wants to be present for all interviews
- Answers for the victim
- Overly attentive, acts loving and compassionate to victim in the professional's presence
- Charming and friendly to health care workers ***or*** abusive to health care workers (e.g., I'll call your supervisor" or "I'll sue you.")
- Uses the system to their advantage or against the victim by knowing "their rights"

WHAT ARE VICTIM BEHAVIORS THAT MAY INDICATE ABUSE? [14]

- Remaining silent when asked questions about the abusive/exploitative acts s/he were subjected too
- Looks to the abuser to answer questions
- Minimize and deny abuse occurs or takes the blame for the abuse (e.g., "If I had been on time when she came to pick me up for church services then this would not have happened.")
- Makes a statement like: "He won't like that." or "I don't think that will be allowed."
- Protecting the abuser – trying to avoid police intervention and the arrest of the abuser
- Asks worker to leave and/or refuses offer of service(s)
- Asks for help and then changes his/her mind
- Doesn't follow through on "the plan"
- Sudden change in behavior
- Fear of being alone with caregiver(s) or family member(s)

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[12] Wisconsin Coalition for Advocacy, Wisconsin Coalition Against Domestic Violence, Wisconsin Coalition Against Sexual Assault and Independence*First. Cross Training Workbook: Violence Against Women with Disabilities.* Madison, WI.: 2004, p.7.

[13] This material was adapted from the handbook, *From a Web of Fear to a Community Safety Net: Cross Training on Abuse in Later Life*, published by the Pennsylvania Coalition Against Domestic Violence in coordination with the Pennsylvania Department on Aging: Harrisburg ,PA., 2001, p. 17.

[14] Ibid., p. 18

- Confusion
- Depression
- Talks fondly of the abuser's good qualities

WHAT ARE SOME REASONS THAT VICTIMS MAY NOT WANT TO REPORT ABUSE? [15]

There are many reasons that victims may be hesitant to report situations of abuse or exploitation. Some victims of family violence may wish to continue their relationship with their abusive family member, hoping that the assaults will stop and the relationship continues. Many other elderly victims fear retaliation if they either disclose abuse or try to leave an abusive situation. Victims who have been abused/sexually assaulted by another resident may be embarrassed or ashamed to talk about what has happened. They may believe they are in some way to blame for the incident. Or they may be afraid that they will not be believed or somehow punished if they tell staff.

Many older adults have additional barriers to reporting the abuse and/or sexual assault that was committed against them. Some of these unique issues include:

- Generational values that instill strongly held beliefs among many older persons that negative issues involving the family should never be discussed. This belief constructs a barrier for many older persons who are assaulted/abused by family members.
- Conflicting feelings toward the perpetrator, if s/he is a family member.
- Lack of information and/or resources about abuse and/or sexual assault and the agencies that might provide services and support.
- Inability to communicate with someone other than the person committing the abuse and/or sexual assault due to isolation, fear or intimidation.
- Inability to communicate verbally due to illness or disability that prevents disclosure.
- Lack of awareness by the older person that what s/he is experiencing or has experienced is abuse and/or sexual assault.
- An attempt to disclose to someone that abuse and/or sexual assault is occurring is met with disbelief or is discounted by the listener because of the victim's age and/or frailty.
- Many older victims of sexual assault may be adult survivors of childhood abuse, so abuse in later life is treated with the same silence that they experienced as children.

WHAT ARE EFFECTS OF ABUSE AGAINST OLDER INDIVIDUALS?[16]

Older adults, like anyone else, will be affected by the trauma of abuse. Everyone experiences trauma differently. Some people will be severely traumatized by their abuse while others may not outwardly appear to have any long-term impact. A "hands-off offense" can severely traumatize one person while a person who was forcibly raped may not seem to experience long-term traumatic affects. Even if the victim could not physically feel or appears to have no memory of the assault, s/he may still be traumatized.

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[15] *Abuse of the Elderly in Regulated Facilities: Report and Recommendations.* Wisconsin Coalition Against Sexual Assault and Wisconsin Coalition Against Domestic Violence, Madison, WI: 2003, p. 20.

[16] *To Live Without Fear and Violence: Sexual Assault and Domestic Abuse Against Older Individuals: Participant Manual and Model Protocols for Law Enforcement Responding to Sexual Assault and Domestic Abuse Against Older Individuals.* Wisconsin Coalition Against Sexual Assault, Inc., Madison, WI., 2004, pages 41 and 42.

Abuse can cause harmful psychological, physical, and behavioral effects. If the abuse is left unaddressed, these affects can potentially be very long lasting and persistent for the individual. It is estimated that 3.5 million women 60 years of age and older are survivors of childhood sexual abuse (Farris and Gibson 1992). Below is a listing of both short-term and long-term effects that may indicate the presence of trauma.

Short-Term Effects

-Anxiety
-Fear
-Anger
-Withdrawal
-Sexualized behavior
-Nightmares or trouble sleeping
-Acting out

Long-Term Effects

-Persistent anxiety and fear
-Feelings of shame or guilt
-Low self-esteem
-Emotional numbness
-Relationship and sexual problem
-Sleep disturbances
-Recurring flashbacks, nightmares, or intrusive thoughts
-Chronic stress and other health problems
-Drug and alcohol abuse
-Suicidal thoughts
-Self-injury
-Eating disorders
-Clinical depression
-Dissociative identity disorder

Older adults have usually developed a vast array of coping skills over their lifetimes. Service providers can assist a victim to recognize these coping skills, how they were applied in the past, and how they can be utilized to address the current situation. It should not be assumed that elderly victims of sexual assault displaying no psychological trauma are unharmed. Many factors determine whether or not internal distress will be openly displayed, including personality, history, cultural and religious background, psychosocial functioning, and cognitive ability[17].

WHAT TYPES OF QUESTIONS SHOULD I ASK ABOUT ABUSE, NEGLECT & EXPLOITATION?

Asking questions about domestic violence and sexual assault in later life must always be done with great care and sensitivity. While it is recommended that entities screen all individuals who they serve concerning family violence within their first week of participation or residency, screening questions should continue to be asked periodically. It is believed that once rapport has been established questions may be asked in a more conversational manner.

[17] "Elder Sexual Abuse Perpetrated by Residents in Care Settings." Holly Ramsey-Klawsnik, *Victimization of the Elderly and Disabled,* March/April 2004, p.93.

Examples of **indirect ways** of asking about abuse, neglect and exploitation include:

- Tell me about who you normally see, volunteer or visit with during the week.
- Who do you especially look forward to seeing, visiting and/or volunteering with?
- Anyone you don't enjoy as much?
- What would you do if someone made you mad? If they wanted you to do something you didn't want to do?
- Do you think you are more assertive at your current age, or were you more assertive when you were younger?
- If you and your (spouse, son, daughter, nurse's aide, physician, etc.) have a disagreement, who usually wins? How do they (you) win?

With more direct questions, prefacing them with a very direct statement would be best. For example, you may wish to start out as follows: "I'm going to ask you some questions about conduct that may be physical, financial or sexual abuse. These can be issues that people have in their lives, but in the past were not asked about. I'm asking about them now, because sometimes people are currently experiencing them, or abuse from the past is affecting how they feel presently."

Examples of **direct questions**[18] follow.

- Has any family member, resident or staff member ever physically harmed you? Have you been struck, slapped or kicked? Has your hair been pulled?
- Have you been tied down or locked in a room?
- Have you been threatened with punishment or deprived of things because you did not comply?
- Have you received the "silent treatment?" Have you been ignored?
- Has anyone touched you in a sexual way without your permission?
- Is money being stole from you or used inappropriately?
- Have you been forced to sign any legal documents (e.g., power of attorney for finances, will) against your wishes?
- Have you been forced to make purchases against your wishes?

Follow-up questions (if abuse is identified):

- How long has the situation been occurring?
- Is it an isolated incident?
- When do you think the next episode may occur?
- Is the person who hurt/harmed you still present in the facility?
- What would you like to see happen?
- Have you ever received help for this problem before?

WHAT SHOULD I SAY IF A RESIDENT DISCLOSES ABUSE OR NEGLECT?

Convey to the patient that she/he does not deserve to be hurt or controlled (if abused) or that she/he has a right to be cared for with dignity and respect (if neglected).

[18] Adapted from: *Elder Abuse.* Laurel H Krouse, MD, Paoli Memorial Hospital, Paoli, PA., eMedicine.com,inc. [Web address: http://www.emedicine.com/emerg/topic160.htm], June 5, 2001.

WHO SHOULD I CALL WHEN I GET STUCK?

Entities should notify local law enforcement authorities in any situation where there is a potential criminal violation of the law. Call the police without delay if someone is in immediate, life-threatening danger.

If the danger is not immediate, but you suspect that abuse has occurred or is occurring, please relay your concerns to the Bureau of Quality Assurance (BQA), the long-term care ombudsman program and/or law enforcement, as appropriate. You may also elect to connect with your county's lead elder abuse agency contact person and if timely, ask to be placed on the next elder abuse interdisciplinary team (I-team) meeting for discussion of the situation. Otherwise, ask the I-team coordinator's opinion on how to best proceed in gaining additional insight (some agencies have a core group that can be pulled together for emergent cases, others have an electronic message board for seeking advice).

The sexual assault or domestic violence program in your area can provide insight and possible advice as well. Calls to elder abuse, sexual assault and domestic violence agencies can occur in an anonymous fashion, i.e., there is not a need to provide identifying information specific to your organization or the resident you are concerned about.

APPENDIX B

BACKGROUND INFORMATION ON THE SEXUAL ABUSE RESPONSE PROTOCOL
Developed by the Sexual Assault/Domestic Violence Industry Training Advisory Group
Wisconsin Department of Health and Family Services
Madison, WI

The Department of Health and Family Services (DHFS) works to improve communication through the development of protocols ensuring systems collaboration and training on documentation of critical information. By facilitating the exchange of information, we can make better choices about what services are appropriate when remedying situations of abuse, neglect and exploitation.

The Sexual Abuse Response Protocol (see next three pages) developed by the Department's Sexual Assault/Domestic Violence Industry Training Advisory Group is an example of efforts to improve communication. The Training Advisory Group, serving in an ad hoc capacity, was convened for the first time on November 29, 2001. The group, comprised of long term care providers, regulators, law enforcement, sexual assault and domestic violence advocates, experts in cognitive impairments and members of the state ombudsman program, met monthly through spring 2002. The group goal was development of training on sexual assault and domestic violence for the Long Term Care Industry and Elder Abuse/Adult Protective Services Programs. The training programs were designed to provide needed information, skills and resources for staff of Wisconsin nursing homes, community-based residential facilities, adult family homes, and residential care apartment complexes on responding to or investigating allegations of abuse or neglect. Included forms of abuse are sexual assault and physical violence of residents by others (such as family members, visitors) within those facilities.

The training was initially piloted in February 2002 at a DHFS sponsored training for staff from the Department's Bureau of Quality Assurance (BQA), the Board on Aging and Long Term Care (Ombudsman program) and interested others. Trainers included a police detective, a Sexual Assault Nurse Examiner (SANE), both a sexual assault and domestic violence advocate and attorneys from the state Departments of Justice and Health and Family Services. In August 2003, DHFS provided training on the protocol to long term care providers representing facilities from throughout the state. The protocol has been adapted by the Wisconsin Coalition Against Sexual Assault (WCASA) for inclusion in a manual developed for law enforcement, victim advocates and elder abuse interdisciplinary teams on how to properly respond to domestic violence and sexual assault, including incidents occurring in facility settings. Training on the manual was provided by WCASA to the target audiences in six regions of the state during the spring of 2004. The Department will incorporate the protocol in future training of staff from BQA, the Ombudsman program and long term care facilities. The Department will also provide technical assistance to facilities working to incorporate the protocol as part of the entity's internal policies and procedures.

For additional information about the Sexual Abuse Response Protocol, please contact DHFS employees Linda Dawson or Jane Raymond. Linda is the Department's Deputy Chief Legal Counsel and may be reached via email at dawsol@dhfs.state.wi.us or by phone at (608) 266-0355. Jane is the Department's Elder Abuse Specialist and may be reached via email at raymoja@dhfs.state.wi.us or by phone at (608) 266-2568.

Background on protocol development provided by J. Raymond, May 17, 2004

Suggested Sexual Abuse Response Protocol

Developed by the SA/DV Industry Training Advisory Group
Wisconsin Department of Health and Family Services
August 2003

GOALS:

1. ENSURE VICTIM'S PHYSICAL AND EMOTIONAL SAFETY
2. Develop systems that avoid victim re-traumatization.
3. Ensure that facility staff responding to a reported sexual assault incident are trained to sensitively and appropriately handle any report.
4. Ensure throughout the entire process the thorough and accurate documentation of information, observations and facility decisions.
5. Ensure that records and any physical evidence are collected, preserved and protected.
6. Provide assistance and support to all victims and hold abusers accountable by conducting adequate and complete investigations.

STEP	PROCEDURES	NOTES
STEP 1: Facility designates a resident contact person to respond to victim needs.	❑ The facility administrator must designate a resident contact person. ❑ The contact person must have specialized training in responding to disclosures of sexual assault and in assessing the primary emotional and physical safety needs of a victim.	• If the designated contact person is not a facility employee, a Memorandum of Understanding (MOU) must be developed with the individual or outside agency that agrees to serve as the first point of contact for a resident victim. • Possible appropriate contact persons include: Facility Administrator, Director of Nursing (DON), Elder Abuse Coordinator, Social Worker, Sexual Assault Service Provider (SASP), or Community Advocate.

STEP	PROCEDURES	NOTES
STEP 2: Facility becomes aware of a suspected sexual assault that involves a resident.	❑ A sexual assault incident including physical or emotional harm or exploitation may be disclosed by a victim, observed by staff or another, or may be suspected. ❑ Determine whether sexual assault is current (that is, within past 28 days).	• Reasons to suspect assaultive behavior include a change in the victim's demeanor or condition, evidence of physical trauma that is consistent with sexual assault, the existence of other medical or physical evidence that may suggest sexual assault, or there are injuries of unknown origin, and an assessed possible cause includes sexual assault. • If <u>current</u>, Sexual Assault Nurse Examiner (SANE) examination may be able to collect forensic evidence; or other physical evidence may be collected, preserved and protected. • If <u>not current</u>, the facility's actions in the following steps may be modified, as appropriate, considering the date the reported assault occurred.
STEP 3: Victim is contacted.	❑ Regardless of the source of information, when there is a report of an assault or when there is reason to suspect sexual assault has occurred, the person designated by the facility should contact the victim as soon as possible but within 24 hours to assess the immediate emotional and physical safety needs of the victim.	• Victim safety needs must take into consideration whether the assault is current and if a medical assessment is needed and wanted by the victim. • Further assessment should include what, if any, steps are necessary to protect the victim from further trauma or harm.

STEP	PROCEDURES	NOTES
STEP 4: Available internal and external resources are contacted and made available to the victim and facility, as appropriate.	❑ Facility social workers, mental health support persons, community advocates (domestic violence or sexual assault), sexual assault nurse examiners (SANE), law enforcement, adult protective services (APS) and lead elder abuse agency workers, regional ombudsmen and staff from the Bureau of Quality Assurance (BQA) may serve as resources or otherwise provide services or consultation to the facility and the victim. ❑ If the victim is *competent or is capable of self-determination*: 1. Does the victim desire support services such as advocacy, counseling about options or specialized therapy? Does the victim wish the facility to contact providers of those services? 2. Does the victim wish the facility to contact law enforcement? 3. Does the victim desire to have a medical examination? 4. Does the victim want any other persons notified, such as persons within the family or close friends? ❑ If the victim *has a guardian or is not capable of self-determination*: 1. Has the guardian been notified, if not the suspected perpetrator? 2. If appropriate, have all possible services, including reporting to law enforcement, been discussed and offered to the guardian on behalf of the victim? (See above for possible resources and services.) 3. What services does the guardian consent to? Follow up in securing any services consented to by the guardian. 4. If the person does not appear able to self-determine next steps, does not have a guardian and the situation is <u>not</u> life threatening, determine whether the person is	• It is recommended as a best practice, that facilities provide notice of their reporting policies to all residents upon admission.

STEP	PROCEDURES	NOTES
	competent or in need of a guardian. You may wish to consult with your county APS agency for advice on determining competency. Proceed accordingly. 5. If the person is not capable of self-determination, does not have a guardian and the situation <u>is</u> life threatening, obtain emergency medical care. If the individual is determined incompetent by a physician, seek appropriate legal authority (e.g., temporary guardianship or a court order) in order to provide necessary services. The county APS agency can assist in determining legal issues and ways to obtain needed protections. Then proceed as follows. ❑ Assess the *risk of continuing harm* to the victim or to others. 1. If the victim is competent or capable of self-determination AND there is no risk of further harm to the victim or others, then the facility should follow the victim's wishes and desires. 2. If the victim or other clients or residents are at risk of physical, emotional or financial harm (including death) by the suspected perpetrator(s), then the facility should report the alleged incident to law enforcement.	
STEP 5: The investigation continues.	❑ An investigation may be by law enforcement, the facility, APS or any others responsible for such an investigation.	

STEP	PROCEDURES	NOTES
STEP 6: Aftercare or follow up.	❑ The facility should assess the after-care needs or wishes for support services of the victim and the victim's family. ❑ The facility should evaluate their own internal intervention processes of the case and determine whether gaps occurred or where the process worked efficiently and make revisions as necessary.	• This may include providing information and referral, medical, psychological or emotional care or other care. • Consideration should be given to prevention strategies as well.

Additional notes:

Date	Note/Comment	Initials or Name

CONTACT INFORMATION (template) ***APPENDIX C***

Abuse, Neglect & Misappropriation (Financial Exploitation) Incidents

AGENCY	PHONE NUMBER
Adult Protective Services (APS) (18-59 yr. old)	
Elder Abuse Agency (EA) (60 plus population)	
Bureau of Quality Assurance (BQA)	(608)243-2019
Department of Regulation & Licensing (DRL)	(608)266-7482
Local Law Enforcement	

Note: Entities should notify local law enforcement authorities in any situation where there is a potential criminal violation of the law. Call the police without delay if someone is in immediate, life-threatening danger.

Agency Type	Report Incident To	Initial Response/ Investigation Done By
Alleged abuser is family, friend, visitor, etc.		
Any Facility Setting	APS/EA	Adult Protective Services/ Elder Abuse
Natural Family Setting *Domestic*	APS/EA	Adult Protective Services/ Elder Abuse
Alleged abuser is employee or contractor		
Adult Day Care	APS/EA	Adult Protective Services/ Elder Abuse
Adult Family Home (AFH) County (1-2 bed)	APS/EA	Adult Protective Services/ Elder Abuse
Adult Family Home (AFH) Private (3-4 bed)	BQA	Noncredentialed staff – BQA Credentialed staff – DRL
Certified AODA/Mental Health Facility	BQA	Noncredentialed staff – BQA Credentialed staff – DRL
Community Based Residential Facility (CBRF)	BQA	Noncredentialed staff – BQA Credentialed staff – DRL
Daily Living Skills or Social Recreation	APS/EA	Adult Protective Services/ Elder Abuse
Day Service Staff	APS/EA	Adult Protective Services/ Elder Abuse
Facility for the Developmentally Disabled (FDD)	BQA	Noncredentialed staff – BQA Credentialed staff – DRL
Non-Medicaid Home Health Agency	APS/EA	Adult Protective Services/ Elder Abuse
Medicaid Home Health Agency	BQA	Noncredentialed staff – BQA Credentialed staff – DRL
Hospice Agency	BQA	Noncredentialed staff – BQA Credentialed staff – DRL
Hospital	BQA	Noncredentialed staff – BQA Credentialed staff – DRL
Nursing Home	BQA	Noncredentialed staff – BQA Credentialed staff – DRL
Professional Credentialed In-Home Provider	DRL	Department of Regulation & Licensing
Residential Care Apartment Complex (RCAC)	BQA	Noncredentialed staff – BQA Credentialed staff – DRL
Supported Employment	APS/EA	Adult Protective Services/ Elder Abuse

Employee/Contractor

- Noncredentialed staff = nurse aide, caregiver, housekeeping, maintenance, dietary, administrative, etc.
- Credentialed staff = registered nurse, licensed practical nurse, physician, social worker, etc.